STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING _____ B. WING _____	C 08/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MUNCIE	2701 LYN-MAR DR MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00114489. This visit was done in conjunction with the Recertification and State Licensure Survey and the Investigation of Complaint IN00112143. Complaint IN00114489 - Unsubstantiated, due to lack of evidence. Survey dates: August 20, 21, 22, 23, 24, and 27, 2012 Facility number: 000097 Provider number: 155687 AIM number: 100290970 Survey team: Betty Retherford RN, TC Julie Call RN Virginia Terveer RN Census bed type: SNF/NF: 100 Total: 100 Census payor type: Medicare: 11 Medicaid: 79 Other: 10 Total: 100 Sample: 7 Golden Living Center-Muncie was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the Investigation of	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING _____ B. WING _____	C 08/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 1 Complaint IN00114489. Quality review 8/30/12 by Suzanne Williams, RN	F 000		